

Mental Retardation (MR) Special Population Workgroup Status Report: August 2, 2004

The MR Special Population Workgroup continues to meet on a regular basis. A SWOT analysis (Strengths, Weaknesses, Opportunities & Threats) determined that three (3) broad issues were of primary concern: building/strengthening community and system capacity, adequate funding, and serving persons with co-occurring mental retardation and mental illness (dual diagnoses). Workgroup members divided into focus groups and developed goals and objectives for each of these consensus issues. For details see the October 2003 Mental Retardation (MR) Special Population Workgroup Report to the Commissioner.

To better manage overall Workgroup activities, four (4) subcommittees were established: Steering Subcommittee, Case Management Subcommittee, Database Subcommittee, and the Dual Diagnosis Subcommittee. The Steering Subcommittee reviews and provides oversight for the wide variety of issues brought up by the full Workgroup. The Steering Subcommittee then makes recommendations to the full Workgroup as to direction, structure and focus of Workgroup priorities. At the specific request of DMHMRSAS, a Case Management Subcommittee's was created to focus on best practice issues for CSB case management. This Subcommittee will work collaboratively with case management committees from mental health and substance abuse services to develop recommendations for statewide best practices in case management. The Database Subcommittee's focus is the design, development and implementation of statewide databases in three (3) areas: community providers, client profiles, and service needs. In cooperation with the Offices of Mental Retardation and Licensure and the Virginia Network of Private Providers, the development and implementation of a statewide community provider database and developmental disability client profile database are priorities. The Dual Diagnosis Subcommittee fully supports the issues and recommendations made in the report of the Northern Virginia MR/MI Workgroup dated July 30, 2003, however, the current Subcommittee has focused its' priorities on education, training and consultation services.

In support of the overall vision of the Mental Health, Mental Retardation and Substance Abuse Services System, the MR Special Population Workgroup established its' mission statement as follows:

Mission Statement

Rebalance Virginia's service system to become more individually focused where people receive services in the community, based on their individualized needs regardless of funding source. This will be accomplished by building capacity for those persons with all levels of developmental disabilities inclusive of co-occurring conditions, which are funded in a manner that is consistent with the values of self-determination.

The MR Special Population Workgroup developed a long list of short-term and long-term objectives for restructuring Virginia mental retardation/developmental disabilities service system. Thru facilitation and consensus the Workgroup prioritized five (5) short-term recommendations for submission to the Commissioner's Restructuring Policy Advisory Committee (RPAC) by the August 2, 2004 deadline. Long-term objectives and priorities have taken somewhat longer to prioritize and will be finalized in the coming months. Each prioritized short-term recommendation listed below provides specific actions steps in the areas of Policy, Administration, Appropriations, and Services.

RECOMMENDATION #1:

Provide training to increase the expertise of community professionals and paraprofessionals to ensure that service providers have the knowledge, skills, and abilities to address current client

needs, evolving complexity of client care, and the decreasing skills of the available workforce for entry-level client care positions.

Actions:

Policy –

- ♦ Extend licensure system to identify providers offering specialty programs and licenses for specialty programs (a tiered license program with specialty certification).
- ♦ Develop a tiered licensing program with specialty certification.
- ♦ Link licensure for specialty programs with training requirements to ensure needed staff knowledge, skills and abilities.
- ♦ Prioritize development/expansion of community and facility services to those with dual diagnosis.

Administrative –

- ♦ Memos of Agreement should be signed by DMHMRSAS Directors' of MR, MH, and SA to establish leadership for an overarching philosophy of a client needs- based system of treatment, rather than the current disability-based system.
- ♦ CSB performance contracts should be enhanced by requiring cross training in assessment and treatment of persons with dual diagnosis.
- ♦ Identify current best practice training programs for community MR services. Establish a standardized training curriculum for CSB case managers, as well as for private provider residential and vocational staff. Develop other training curriculum as needed.
- ♦ Support provider participation in training curriculum to assure minimum standards of training for all staff. (e.g., by supporting the direct care professional training through The College of Direct Support from the University of Minnesota program).

Appropriations –

- ♦ Support funding for development of a standardized training curriculum.
- ♦ Support funding for training materials and costs of trainers.
- ♦ Support supplement funding for community providers so they can obtain reimbursement for direct care staff's pay during required training.
- ♦ Support funding for development of MR/MI PACT Teams.
- ♦ Provide incentives for clinical providers to attend training, such as CEU's and tax credits.

Services –

- ♦ Expand service options for children/adolescents with MR with strong emphasis on in-home family supports.
- ♦ Provide cross training of CSB MH, MR and SA staff at all levels. Adopt mandatory performance expectations for direct care/clinical staff in the assessment and treatment of persons with dual diagnosis.
- ♦ Identify and/or develop regional experts to provide consultation and training to community clinical providers.
- ♦ Develop regional MR/MI PACT Teams.

RECOMMENDATION #2:

Develop policies that do not have a negative financial impact on community private providers when clients need temporary out-of-home placements (e.g., hospitalization) or spend time with family to sustain relationships. Recognize that funding the individual includes, and requires, that the person have stable housing.

Actions:

Policy –

- ♦ DMHMRSAS to fully support the assertion that residential private providers are providing a essential resource that is vital to community integration of clients, and therefore, capacity to hold the residential placement during temporary out-of-home placements is critical to successful community integration.

Administrative –

- ♦ Direct DMHMRSAS to work with DMAS and other agencies to resolve the discrepancy between the individual's need for stable, continuing housing and current Waiver funding constraints to maintaining placements when out-of-home services are needed.

Appropriations –

- ♦ Conduct analysis of costs regarding current duration and reasons for client absences from community placements.
- ♦ Create an equitable mechanism to allow reimbursement of both ICF/MR and MR Waiver programs for consumer absences due to hospitalization and other temporary circumstances in order to maintain a person's home.

RECOMMENDATION #3:

DMHMRSAS request increased funding for community services each year, specifically related to maintenance of current services (e.g., utilization, inflation, and COLA) and expansion of services.

Actions:

Policy –

- ♦ DMHMRSAS requests for funding to community services will be developed so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR. In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS budget development should address:
 - Analysis of regional environmental factors (i.e., economy, workforce availability & competition, unemployment and population trends).
 - Identification and analysis of the per capita rate and number of persons who are uninsured in each region.

Administrative –

- ♦ In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS should conduct a formal needs assessment of regional services to persons with MR.

Appropriations –

- ♦ Expand the types of Medicaid Waivers for MR community services. Provide increased funding at levels that will ensure maintenance and stability of current community services as well as necessary expansion.

RECOMMENDATION #4:

Create a statewide database that matches needed supports of persons with developmental disabilities with qualified providers. This database will be also used for planning future service needs and funding requests.

Actions:

Policy –

- ♦ DMHMRSAS will require the Office of Mental Retardation to spearhead a system-wide effort to collect and maintain a database that facilitates the match between consumers, service needs, and providers of residential and vocational options.

Administrative –

- ♦ The Database Subcommittee of the MR Special Populations Work Group will develop recommended data elements for the profile needs of providers, consumers and services.
- ♦ DMHMRSAS will develop a statewide database system for this purpose using existing databases where appropriate.

Appropriations –

- ♦ Identify and provide necessary funding for DMHMRSAS staff to develop, implement, and maintain the database.
- ♦ Identify and provide necessary funding to support on-going training and use of the database by the Office of Licensure, Office of Mental Retardation, CSB case management staff, and private providers.

RECOMMENDATION #5:

Improve overall funding to promote and reward best practice support strategies for all staff in order to increase stability of direct support professionals through:

- Training, development, and credentialing
- Tax credits to employers and providers
- Staff salaries and benefits that reflect regional economic and other environmental factors (e.g., job competition, workforce availability, cultural diversity, etc.)

Actions:

Policy –

- ♦ Establish legislation that ensures the continuation of adequate funding for the community-based system through adoption of public policy that includes an annual cost of living increase for all services.

Administrative –

- ♦ Increase collaboration between DMHMRSAS and other State agencies to obtain additional funding from Federal sources (i.e. SAMHSA for dual diagnosis projects).
- ♦ DMHMRSAS funding requests for community services will be developed so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR.
- ♦ In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS budget development should address regional factors (i.e., economy, workforce availability & competition, unemployment, cultural diversity, and population trends).

Appropriation –

- ♦ DMHMRSAS will encourage funding of such initiatives with the support of advocacy organizations.
- ♦ DMHMRSAS should submit a proposal to the General Assembly to provide supplemental funding to community providers for training of direct care staff due to lack of reimbursement for staff pay when a client is not yet residing in the home (i.e., as a part of start-up costs).

Services –

- ♦ Support provider participation to assure minimum standards of training for staff (e.g. by supporting the direct care professional training through the College of Direct Care University of Minnesota program).
- ♦ Expand the types of Medicaid Waivers for MR community services.

In closing, the MR Special Population Workgroup did not include any comments above about the very important process for assuring a person's' choice of providers because we felt so strongly that this should be addressed separately and immediately by DMHMRSAS. The process for assuring choice of providers responds to Budget Item 329, passed by the Virginia General Assembly in the 2002 session, which stipulates that "The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, in cooperation with community services boards and private service providers, shall ensure that consumers are allowed choices in selecting group home placements and services"

The Office of Mental Retardation established a workgroup, including representatives of the Virginia Network of Private Providers, Community Services Boards, the Department of Medical Assistance Services and advocates to establish the process for assuring choice of eligible providers. The attached *Protocol For Resolving Issues Regarding Choice In Virginia's Mental Retardation Home and Community Based Waiver Services* has been reviewed and unanimously approved by the MR Special Population Workgroup. Given the large number of Home and Community Based Waiver slots recently approved and funded, it is imperative that this protocol be finalized and distributed by DMHMRSAS in order to provide support to this important community initiative.

See attachment entitled *Protocol For Resolving Issues Regarding Choice In Virginia's Mental Retardation Home and Community Based Waiver Services*

Protocol For Resolving Issues Regarding Choice In Virginia's Mental Retardation Home and Community Based Waiver Services

The process for assuring choice of providers responds to Budget Item 329, passed by the Virginia General Assembly in the 2002 session, which stipulates that "The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, in cooperation with community services boards and private service providers, shall ensure that consumers are allowed choices in selecting group home placements and services"

The Office of Mental Retardation established a workgroup, including representatives of the Virginia Network of Private Providers, Community Services Boards, the Department of Medical Assistance Services and advocates to establish the process for assuring choice of eligible providers. The following protocol will be effective upon distribution by the Department.

The rights of Medicaid-eligible persons to choose the provider of services they receive under Virginia's Medicaid State Plan, as well as the Mental Retardation Home and Community Based Waiver, are established in Section 1902 of the Social Security Act, and are therefore prerequisites to receiving federal Medicaid reimbursement.¹ Furthermore, the rights of all of Virginia's citizens with mental retardation to access services of their choosing that reflect their need for community support is a value that is held by the professional service community. This Protocol has been developed to offer guidelines to Community Services Boards and other providers of support services who struggle with issues of limited resources and consumer needs while adhering to the principles and mandates of "choice." Service providers for a particular consumer assure that they will work collaboratively in offering supports and will, at all times, mutually respect the consumer's choice. The term "providers" in this document will refer to public, private and contracted providers of support services operating with MR Waiver funds.

I. Methodology For Determining The Available Providers For A Given Area

- **The Office of Mental Retardation Services (OMRS) will receive information from the Department of Medical Assistance, or their designee, regarding enrollment of all MR Waiver providers and the services approved.**
- OMRS will distribute a questionnaire to newly enrolled providers requesting a list of the potential geographic areas to be served for each service type and the potential geographic areas in which services will be provided.
- Providers are responsible for notifying the OMRS Central Office of updates to the "Provider List" to ensure the information remains accurate and current, including specific license or certification (such as type of Therapeutic Consultation or Respite services) or program modifications that sufficiently alter the services (such as Day Support services licensed by DMHMRSAS opting to provide only prevocational services through a DRS vendor agreement).
- The "Provider List" will be distributed twice each calendar year in March & October to all providers on the list, including Community Services Boards. This list will identify the geographic areas the providers have expressed a desire to serve. To the greatest extent possible the list will include the licensing/certification status at the time the list is produced.

- Providers must also notify the CSBs in whose catchment areas they wish to provide services of their existence and availability. This should be done through a letter of introduction, and include a list of services and the contact person for information or referral for each.
- Each CSB will maintain a list of the providers available to provide services in their area. This list will be updated twice each year to remain current with the Central Office Provider List.

II. Methodology of Offering Options to Consumers/Families

- Choice of providers is always an option and can be exercised by individuals once they have obtained a Medicaid Waiver slot.
- The CSB is responsible for reviewing with the individual/authorized representative the list of available providers (1) at the initiation or start-up of any services, (2) whenever requested thereafter, (3) if the case manager has reason to believe that the individual may benefit from offering choice of providers and (4) if the individual/authorized representative expresses dissatisfaction with current services.
- Neither the case manager nor any other public or private provider representative will offer another program as an alternative choice to an individual already receiving services in a like program except in one of the specific circumstances listed in bullet #2 above.
- Case managers will provide the support needed by the individual/authorized representative to contact the provider(s) of interest. All provider(s) of interest will be contacted or reviewed with the individual/authorized representative.
- Documentation of individual choice opportunities will be noted in the case management record. This documentation should be provided in a consistent format throughout Virginia's service system. (See attached form.)
- Case managers will provide factual information in regard to service providers and will provide guidance that is necessary for each consumer to make an informed choice.
- All providers of MR Waiver services must provide reasonable access to CSB case managers working with recipients or applicants for the service, including case notes, progress reports and the physical premises where services are provided.
- Should the CSB have concerns regarding the capacity of a provider to support the health and safety needs of current or prospective individuals based on known or observable deficiencies in program capacity, the CSB should follow the protocol below (which appears in the "MR Community Services Manual," Chapter 4, p. 12):

"If there is evidence of serious problems revealed upon CM review including 1) the individual, authorized representative, or primary caregiver is dissatisfied with services, 2) services are not delivered as described in the CSP, or 3) the individual's health and safety are at risk, the case manager must take necessary actions and document in the individual's appropriate record (s). Actions may include: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency, DMHMRSAS and DMAS; informing the individual or other providers of the service in question; and as a last resort, after all other options have been exhausted, informing the individual that eligibility may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure

health and safety. Any time abuse or neglect is suspected, the case manager is required to inform the Department of Social Services.”

If the conditions of the program are so severe as to pose an immediate risk of exploitation, physical and/or emotional abuse, the CSB case manager should notify the Department of Social Services’ Adult Protective Services Unit in the jurisdiction in which the individual resides.

- OMRS may respond to reports about a deficient provider in one or more of the following ways: 1) provide technical assistance to the provider in methods to improve their programming standards, 2) contact the licensing or credentialing agency regarding deficiencies that compromise the licensing status, or 3) inform DMAS that a program is not operating in accordance with the Medicaid provider agreement.

III. Individual Satisfaction Issues Resulting in Request to Change Provider

- The current quarterly requirement for case managers to assess and document individual/authorized representative satisfaction is viewed under the protocol as the responsibility of both the case manager to solicit information and of the individual to provide honest feedback concerning satisfaction of services. If an individual with mental retardation has difficulty with communication, the case manager should look for behavioral clues indicating his or her true sentiments. Observations by family, authorized representatives and others should be considered as well.
- The individual, authorized representatives, providers and others should communicate issues of dissatisfaction with services to the case manager at any time, without waiting for the quarterly review.
- Providers have the responsibility for notifying the case manager if the individual expresses dissatisfaction directly or if dissatisfaction with the services is suspected through the individual's behavior or by report from significant others.
- If the individual expresses dissatisfaction, the CSB Case Management System must have a mechanism that addresses this dissatisfaction with the provider. At a minimum, the case manager must:
 - Discuss with the individual/authorized representative ways to resolve issues and concerns to promote stability in the consumer's placement while focusing on the preferences and interests of the individual.
 - Attempt a meeting with all relevant parties to resolve the issues.
 - If the potential for conflict of interest exists or the individual's choice is unclear, then a neutral facilitator, agreed to by all parties, will be called in to attempt resolution.
- To accomplish a successful transition, ensure continuity of care, and accommodate the unique needs of the individual, the case manager will encourage the current and prospective providers and the individual/authorized representative to allow for a reasonable transition period and process.
- Public, private and contracted providers have the option at any time to contact the Office of Mental Retardation through regionally-assigned Community Resource Consultants to obtain guidance and consultation in methods to improve programming and/or address an individual's dissatisfaction with services. It is within the scope of the Community

Resource Consultant's responsibility to provide objective, professional assistance directed toward quality improvement, as opposed to issuing, or causing to be issued, any penalties for inappropriate operation of the program, unless violations are of such a serious nature as to compromise the health and safety of program recipients or appear fraudulent. Community Resource Consultants may also provide guidance and consultation to providers as a result of quality issues noted during a Utilization Review, conducted by the Department of Medical Assistance Services.

IV. Methodology for Assuring Choice

- The case manager will maintain a standard form in the case management record, which documents that choice of providers has been offered to the individual and authorized representative, as specified in Section II.
- Should any individual, authorized representative or provider feel that provider choice has not been adequately offered, information has been biased or incorrect, or that the individual or authorized representative has not been encouraged to participate in the decision making process, the individual, authorized representative or provider may:
 - Utilize the complaint resolution process developed by the CSB; or
 - File a complaint with DMHMRSAS Office of Licensing, DMHMRSAS Office of Mental Retardation or DMAS. The recipient of the complaint will conduct an investigation and take appropriate action.

¹ Social Security Act

SEC. 1902. *[42 U.S.C. 1396a]* (a) A State plan for medical assistance must—
(23) Provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section [1915\(b\)\(1\)](#)), a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section [1905\(a\)\(4\)\(C\)](#), except as provided in subsection (g), in section [1915](#), and in section [1932\(a\)](#), except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan
